The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Department of Public Health
Radiation Control Program
Schrafft Center, Suite 1M2A
529 Main Street, Charlestown, MA 02129
(617) 242-3035 (617) 242-3457 - Fax

MITT ROMNEY
GOVERNOR

KERRY HEALEY
LIEUTENANT GOVERNOR

RONALD PRESTON
SECRETARY

PAUL J. COTE, JR.
COMMISSIONER

APPLICATION FOR AN INDIVIDUAL GRADUATED FROM A COMMITTEE ON ALLIED HEALTH EDUCATION AND ACCREDITATION (C.A.H.E.A.) APPROVED RADIOLOGIC TECHNOLOGIST PROGRAM(S)

1. _____ ____/____/_____
NAME (PLEASE PRINT) DATE OF BIRTH

_____
ADDRESS

_____
CITY/TOWN STATE/ZIP

_____ _____ _____
SS# HOME TELEPHONE DAYTIME TELEPHONE

2. RADIOLOGIC TECHNOLOGIST TRAINING:

Dates of training Completed _____ /____ to _____ /___
Month Year Month Year

Date of graduation: _____ /___
Month Year

Area of Study _____ radiography, full
_____ nuclear medicine
_____ radiation therapy

College providing training:

Name: _____

Address: _____

_____

3. NOTE: Attached to this form, you must include proof of successful completion of all school requirements either in the form of a letter signed by your program director indication this, or a copy of your diploma/certificate showing graduation from a radiologic technologist program.

4. I, _____, hereby apply for a temporary license as a radiologic technologist. I have read and understand the provisions of the Commonwealth of Massachusetts Law, Chapter 111 Section 5K, and the regulations established by the Commission. I further grant permission to the licensing agency to verify any or all of the information that I have furnished.

Applicant's Signature: _____ Date: _____

5. RETURN TO: RADIOLOGIC TECHNOLOGIST LICENSING
c/o RADIATION CONTROL PROGRAM
MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH
SCHRAFFT CENTER, SUITE 1M2A
529 MAIN STREET, CHARLESTOWN, MA 02129